828 Elmhurst
Salina, Kansas 67401
785-827-2500

Date_____ Account_____

Patient Payment Agreement

DUE TO THE BALANCE ON MY ACCOUNT, I WOULD LIKE TO MAKE THE FOLLOWING ARRANGEMENTS FOR PAYMENT:

( ) I_____AGREE TO MAKE PAYMENTS TO

HEARTLAND DERMATOLOGY IN THE AMOUNT OF $_____.

I WILL MAKE MY FIRST PAYMENT ON _____ AND THEN EVERY

MO._____, 2 WEEKS_____, WEEK_____, UNTIL MY ACCOUNT BALANCE IS PAID IN FULL.

I UNDERSTAND THAT IF MY PAYMENT IS NOT MADE OR IS NOT ON TIME, MY ACCOUNT

WILL BECOME DELINQUENT AND SUBJECT TO COLLECTION PROCEDURES.

( ) I WOULD LIKE TO CHARGE TO MY CREDIT CARD. PLEASE CIRCLE CARD NAME.

MASTER CARD VISA DISCOVER CARD
NAME ON CARD _____
CARD # _____ EXP. DATE_____
AMOUNT _____
SIGNATURE _____
Or you may call (785) 820-2731 with card information.

_____ _____
Signature Witness

_____
Street Address

_____
City/State/Zip

_____
Phone